

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____
 Age _____ Sex _____ Grade _____ School _____ City _____ Telephone _____
 Present Address _____

Cleared without restriction Cleared, with the following qualifications: _____

Not cleared for All sports Certain sports: _____ Reason: _____
 Recommendations: _____

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO): _____ OR APNP _____

Address _____ City _____ State _____ Zip Code _____
 Telephone _____ Date of Examination _____

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

* Physicians may authorize Nurse Practitioners or Physician Assistants to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

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Preparticipation Physical Evaluation (Medical History to be Retained by Physician/Provider)

HISTORY FORM

DATE OF EXAM _____ (First) _____ (Middle Initial) _____ Date of birth _____

Name (Last) _____ (First) _____ (Middle Initial) _____ Date of birth _____

Grade _____ Age _____ Sex _____ School _____ Sport(s) _____ Telephone _____

City _____ State _____ Zip Code _____ Telephone _____

Personal Physician _____ Telephone _____

In case of emergency, contact _____ Telephone (H) _____ (W) _____

Name _____ Relationship _____

Explain "Yes" answer(s) below. Circle questions you don't know the answers to.

- | | | | | | | | | | | | | | | | | | |
|---|------------|----------|-----------|-----------|-----------|---------------|---------------|-------|------------|------------|-----|-------|------|-----------|-------|-----------|--|
| <p>1. Has a doctor ever denied or restricted your participation in sports for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have an ongoing medical condition (like diabetes or asthma)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have allergies to medicines, poisons, foods, or stinging insects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Has a doctor ever told you that you have (check all that apply):
 <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur
 <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection
 <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection</p> <p>10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Has any family member or relative died of heart problems or of sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Does anyone in your family have Marfan syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever spent the night in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below.</p> <p>18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below.</p> <p>19. Have you had a bone or joint injury that required x-rays, MRI, CT surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper arm</td> <td>Elbow</td> <td>Forearm</td> <td>Hand/ fingers</td> <td>Chest</td> </tr> <tr> <td>Upper back</td> <td>Lower back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/shin</td> <td>Ankle</td> <td>Foot/toes</td> </tr> </table> <p>20. Have you ever had a stress fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Do you cough, wheeze, or have difficulty breathing during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/ fingers | Chest | Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/toes | <p>25. Is there anyone in your family who has asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Have you had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Do you have headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Are you happy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>FEMALES ONLY</p> <p>47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. How old were you when you had your first menstrual period? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>49. How many periods have you had in the last 12 months? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Explain "Yes" answers here: _____

 _____</p> |
| Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/ fingers | Chest | | | | | | | | | | |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/toes | | | | | | | | | | |

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

Student's Name _____
 Parents' Place of Employment _____
 Family Physician _____ Family Dentist _____
 Name of Private Insurance Carrier _____ Telephone _____
 Subscriber Member Name (Primary Insured) _____

Emergency Information

Allergies _____

Other information (medication, etc.) _____

Immunizations Up to date (see attached documentation) Not up to date - specify (e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomylitis; pneumococcal; meningococcal; varicella)

- I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card.
- Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

Preparticipation Physical Evaluation
 (Medical History to be Retained by Physician/Provider)

PHYSICAL EXAMINATION FORM

Name (Last) _____ (First) _____ (Middle Initial) _____ Date of birth _____
 Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____ / _____ / _____
 Vision R 20 / _____ L 20 / _____ Corrected: Y N PUPILS: EQUAL _____ UNEQUAL _____

- Yes No**
- Follow-Up Questions on More Sensitive Issues**
- Do you feel stressed out or under a lot of pressure?
 - Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
 - Do you feel safe?
 - Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - During the past 30 days, have you had at least 1 drink of alcohol?
 - Have you ever taken steroid pills or shots without a doctor's prescription?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Questions from the Youth Risk Behavior Survey (<http://cdc.gov/HealthyYouth/yrb/index.htm>) on guns, seatbelts, unprotected sex, domestic violence, drugs, etc.

Notes: _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.
 +Having a third party present is recommended for the genitourinary examination

Notes: _____

Name of physician or APNP (print/type) _____ Telephone _____ Date: _____
 Address _____ MD/DO or APNP: _____

Signature of physician: _____
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